View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Elsevier - Publisher Connector

crease the dose/frequency of octreotide-LAR as 2nd-line therapy in patients with uncontrolled symptoms up to 60 mg every 4 weeks or up to 40 mg every 3 or 4 weeks for refractory carcinoid syndrome; and 3) as 3rd-line therapy, antiangiogenic therapy may be active in patients with carcinoid tumors. **CONCLUSIONS:** Treatment consensus obtained in this study is concordant with NCCN recommendations. The Delphi process, however, permitted more detailed medical treatment guidelines in a range of key areas in midgut NETs.

PCN117

AN EXPERT PANEL CONSENSUS ON MEDICAL TREATMENT OF NON-MIDGUT UNRESECTABLE NEUROENDOCRINE TUMORS

Benson AB[1], Strosberg JR[2], Fisher G[3], Malin JL[4], Anthony L[5], Arslan B[2], Gibbs JF[6], Greeno E[7], Iyer R[6], Kim MK[8], Maples W[9], Philip PA[10], Wolin E[11], Cherepanov D[12], Broder M[12]
[1]*Robert H. Lurie Comprehensive Cancer Center of Northwestern University, Chicago, IL, USA,* [2]*University of South Florida College of Medicine, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL, USA,* [3]*Stanford University Medical Center, Stanford, CA, USA,* [4]*University of California, Los Angeles, CA, USA,* [5]*University of Kentucky Medical Center, Lexington, KY, USA,* [6]*State University of New York at Buffalo, Roswell Park Cancer Institute, Buffalo, NY, USA,* [7]*University of Minnesota, Minneapolis, MN, USA,* [8]*Mount Sinai Medical Center, New York, NY, USA,* [9]*Mission Health System, Asheville, NC, USA,* [10]*Wayne State University School of Medicine, Karmanos Cancer Institute, Detroit, MI, USA,* [11]*Samuel Oschin Cancer Center, Cedars-Sinai Medical Center, Los Angeles, CA, USA,* [12]*Partnership for Health Analytic Research, LLC, Beverly Hills, CA, USA*

OBJECTIVES: Gastrointestinal neuroendocrine tumors (NETs) are rare and current treatment guidelines lack specificity in some clinical areas. We present a panel consensus on medical treatment of well-differentiated (grade 1-2 tumors) unresectable non-pancreatic non-midgut NETs. **METHODS:** NET treatment appropriateness ratings were collected using the RAND/UCLA Delphi process. We recruited physician experts (criteria: specialty, geography, practice), reviewed NET treatment literature, and collected 2 rounds of ratings (before and after a face-to-face meeting) from the experts. Experts and the moderator were blinded to the funding source. Patient scenarios (rated on a 1-9 scale indicating appropriateness of various interventions for a given scenario) were labeled as appropriate, inappropriate, or uncertain. Scenarios with >2 ratings from 1-3 and >2 from 7-9 range were considered to have disagreement and were not assigned an appropriateness rating. **RESULTS:** Ten panelists had a mean age of 50.4 years. Specialties represented were medical and surgical oncology, interventional radiology, and gastroenterology, and all practices were affiliated with academic institutions. Panelists had practiced between 6-33 years. Among 202 non-midgut rated scenarios, disagreement decreased from 16.2% (32 scenarios) before the meeting to 3% (6) after. In the 2nd round, 42.1% (85 scenarios) were rated inappropriate, 34.2% (69) were uncertain, and 20.8% (42) were appropriate. Consensus statements from the scenarios include: 1) observation is appropriate in patients with no symptoms and low-volume radiographically-stable disease; 2) somatostatin analogs may be appropriate in patients with secretory symptoms; and 3) everolimus or interferon-α can be considered in patients who progressed radiographically or symptomatically on somatostatin analogs. **CONCLUSIONS:** We obtained appropriateness ratings of variety medical therapies in NETs from expert physicians. The Delphi process enabled participants to systematically quantify their assessment of the literature in a valid and reliable way while improving overall panel consensus on the appropriateness of medical therapies in non-midgut NETs.

PCN118

PROMOTING TOBACCO CESSATION AMONG CANCER PATIENTS: A NATIONAL SURVEY AMONG ONCOLOGY PROVIDERS IN THE UNTIED STATES

Tworek C, Bhattacharjee S, Kinney J, Madhavan S
West Virginia University School of Pharmacy, Morgantown, WV, USA

OBJECTIVES: Tobacco use following cancer diagnosis is a serious concern for negative health outcomes. Despite ill-effects of tobacco among cancer patients and negative implications for treatment, many patients continue to use tobacco. Oncologists have a pivotal role in promoting tobacco cessation throughout treatment. This study assessed knowledge, readiness, and willingness to conduct and promote tobacco cessation counseling among a national sample of currently licensed practicing US Oncology providers. **METHODS:** A brief survey was administered in July 2011 via e-mail (N=3006) and US postal mail (N=1000). Samples were obtained from SK&A Information Services, Inc., which used verified addresses and broadcast e-mail surveys with one follow-up. Response rates were 0.6% for e-mail (N=19) and 9.6% for postal mail (N=96), with a 2.9% overall response rate (N=115). **RESULTS:** Results showed a majority of oncologists do the following often/almost always with patients: ask about tobacco use (96.6%); document tobacco use (93.1%); discuss tobacco use as a cancer risk factor (87.9%); counsel patients on quitting (72.8%); and assess readiness to quit (68.7%). Findings, however, also reported a majority of oncologists do the following never/rarely with patients: provide information about secondhand tobacco smoke (53.5%); provide information on quitlines (59.7%); provide brochures and self-help guides (64.3%); and follow the 5A's model for tobacco treatment (68.6%). On a scale of 0-10, providers indicated they were generally comfortable providing cessation counseling [mean=7.0; SD=2.4]; however, providers were less willing to participate in a tobacco cessation training program for assisting patients with quitting [mean=5.2; SD=3.4]. **CONCLUSIONS:** Findings suggest oncology providers are asking, documenting use, and counseling patients who continue to use tobacco during treatment. Education targeting providers can increase knowledge and practices related to the 5A's treatment model, promoting quitline and self-help information for patients. Effective strategies increasing provider willingness to attend tobacco treatment training sessions should also be encouraged.

PCN119

CHEMOTHERAPY TREATMENT AND SURVIVAL OUTCOME

Lim YS[1], Lim GCC[2]
[1]*Ampang Hospital, Ampang, Selangor, Malaysia,* [2]*Kuala Lumpur Hospital, Kuala Lumpur, Kuala Lumpur, Malaysia*

OBJECTIVES: The main objective was to determine the chemotherapy treatment and outcome. **METHODS:** Data was collected from 1 June 2008 till 31 December 2008 in Hospital Kuala Lumpur (HKL) using web-based application. Survival data would be obtained via linkage with Registration Department after four years. Data analysis was with STATA statistical software. **RESULTS:** The total number of patients was 1192.There were 56% females and the most common age group was 50-59 years. The major ethnic groups were Malay (46.5%), Chinese (37.3%) and Indians (13.8%). Most patients at the oncology clinic at HKL have good performance status with ECOG 0-1 (61.5%). The most prevalent cancers were breast cancer (24.5%), colorectal cancer(17.4%), bronchus and lung cancer 8.6%, cervical cancer 6.5% and nasopharyngeal cancer (NPC) 6.2%. Most solid tumours were treated by multimodality. 48.8% received 2 or more modalities . There were 547 patients (45.9%) that received radiotherapy and 32.2% that received chemotherapy. 384 patients were given cytotoxic chemotherapy . Most patients (84,1%) received just one regime. The most common regime was a combination of Fluorouracil, Epirubicin and Cyclophosphamide ie FEC (16.4%.) The most often used cytotoxic drugs used were Fluorouracil (26.3%), Cisplatin (15%) followed by Cyclophosphamide (9.9%), Epirubcin (7.3%), Capecitabine (6.4%), Docetaxel (4.2%), Gemcitabine (3.7%). The most often used route of administration was intravenous (92.6%) mostly infusion as opposed to bolus. Capecitabine was the cytotoxic dug that was the most widely used in the oral form. **CONCLUSIONS:** This is only sub-study of a long term research that began in 2008 in HKL.. Patterns in chemotherapy usage would change as new drugs emerged in the Formulary. The database would be sustained as a platform for future researches and for survival analysis. (283 words).

PCN120

THE IMPACT OF UNIVERSAL HEALTH INSURANCE COVERAGE ON USE OF MEDICINES FOR NON-COMMUNICABLE DISEASES IN THAILAND

Garabedian LF[1], Ross-Degnan D[1], Stephens P[2], Ratanawijitrasin S[3], Wagner A[1]
[1]*Harvard Medical School, Boston, MA, USA,* [2]*IMS Health Consulting Group, London, UK,* [3]*Mahidol University, Salaya, NakornPathom, Thailand*

OBJECTIVES: In 2001, Thailand implemented the 30 Baht Scheme, a public insurance scheme that covers the poor and uninsured and pays providers through a capitated payment scheme. Our objective is to evaluate the impact of the 30 Baht Scheme on use of medicines in Thailand for three non-communicable diseases: cancer, cardiovascular disease, and diabetes. **METHODS:** We used an interrupted time series design to measure the impact of the 30 Baht Scheme on total pharmaceutical market volume and market share. We used IMS Health data on quarterly purchases of medicines from hospital and retail pharmacies from 1998 to 2006. **RESULTS:** The 30 Baht Scheme was associated with long-term increases in hospital sector sales of medicines for conditions that can be adequately treated in outpatient and primary care settings (e.g., diabetes, high cholesterol and high blood pressure). The policy was associated with no change in sales of medicines for more life-threatening diseases, which are more appropriately treated in secondary or tertiary settings (e.g., myocardial infarction, stroke and cancer). The majority of sales were for essential medicines, yet there were also post-policy increases for non-essential medicines. Immediately following the reform, there was a significant shift in hospital sector market share by licensing status for most classes of medicines. We observed large increases in government-produced products, primarily at the expense of branded generics. **CONCLUSIONS:** Our results suggest that expanding health insurance coverage with a medicines benefit to the entire Thai population increased the volume of medicine sales in primary care hospitals. Our study, however, also suggests that implementation of the 30 Baht Scheme may have been associated with possibly undesirable effects: increased use of non-essential medicines and decreased use of less expensive generics and medicines in secondary and tertiary settings. Thorough evaluation of desired and undesired effects of universal health insurance programs are urgently needed.

PCN121

EVALUATION OF AROMATASE INHIBITOR UTILIZATION AND FAILURE IN POST-MENOPAUSAL WOMEN WITH ADVANCED ER+/HER2- BREAST CANCER

Landsman-Blumberg P[1], Namjoshi M[2], Thomson E[1], Johnson W[1]
[1]*Thomson Reuters, Washington, DC, USA,* [2]*Novartis Oncology US, East Hanover, NJ, USA*

OBJECTIVES: To compare the demographic, clinical and treatment characteristics of post-menopausal women with advanced ER+/HER2- breast cancer (BC) treated with aromatase inhibitors (AI) who experienced 0 or ≥ 1 AI failure (AIF). **METHODS:** Women ≥ 55 years old, newly diagnosed with metastatic ER+/HER2- BC (index) were identified from the 2006-2010 *Thomson Reuters MarketScan* databases. Patients in the 6-month pre- or variable post-index periods treated with endocrine (ET: tamoxifen, fulvestrant) or AI (anastrozole, letrozole, or exemestane) therapy (ER+) and not with trastuzumab or lapatinib (HER2-), with no pre-index diagnosis of primary cancer other than BC, and post-index treatment with ≥ 1 AI were retained. AIF was defined post-index as a switch to an alternative AI, ET, or chemotherapy, or AI discontinuation with no further BC treatment. **RESULTS:** Among 4274 ER+/HER2- BC patients studied, 61% had ≥ 1 AIF (80% had 1 and 20% had 2+ AIFs). There was no difference in pre-index AI use (54.4% no AIF, 51.8% AIF; p=0.093). At index, AIF patients were more likely to be Medicare-eligible (57% vs. 51%) with liver (7% vs. 4%), lung (10% vs. 8%), bone (56% vs. 48%), and brain (7% vs. 5%) metastases, all p<0.03. Mean follow-up days was shorter for AIF patients (486 vs. 522, p=0.006). First line AI and ET treatments were respectively 95% and 5% for AIF and 97% and 3% for no AIF patients. The most common first line therapy was anastrazole (49%